

EXHIBIT 2

Redacted SC Workers' Compensation Commission Claim

South Carolina Workers' Compensation Commission
 1333 Main Street, Suite 500
 P.O. BOX 1715
 Columbia, SC 29202-1715
 (803) 737-5723



WCC File #: 2207465
 Carrier File #: E2G65611 J2
 Carrier Code #: 127-1
 Employer FEIN #: 20-1998367

Claimant's Name: Lauren Ballard Employer's Name: Weston & Sampson Inc.
 Address: 835 Midland Pkwy Apt 208 Address: 55 Walkers Brook Dr, Ste 100
 City: Summerville State: SC Zip: 29485-8172 City: Reading State: MA Zip: 01867-3272
 Home Phone: (828) 691-5433 Work Phone: () - Insurance Carrier: National Fire Insurance Company Of Hartford
 Preparer's Name: Kristina Dickson Law Firm: _____ Preparer's Phone #: (877) 371-5421

Compensation Paid:	Number of Weeks	From (m/d/yyyy)	To (m/d/yyyy)	Amount
1. Number of Weeks T.T.	_____	_____	_____	\$ _____
2. Number of Weeks T.P.	_____	_____	_____	\$ _____
3. Number of Weeks P.P.	_____	_____	_____	\$ _____
4. Disfigurement	_____	_____	_____	\$ _____
5. Agreement and Final Release	_____	_____	_____	\$ _____
Total Compensation Paid				\$ <u>0.00</u>
6. Total Medical Benefits* Paid	_____	_____	_____	\$ _____
7. Funeral Benefits	_____	_____	_____	\$ _____

☒ Case Denied

Date of Injury: 03/31/2022
 (m/d/yyyy)

By signing this receipt, I acknowledge that I have received the compensation shown above.

By: _____
 Claimant

By: _____
 Employer's Representative

 Date
 (m/d/yyyy)

Print or type the name of the person, other than the claimant, receiving benefits and sign below.

By: _____

Report of Additional Fees and Recoupment

A. Carrier Reimbursement by Third Party	_____	\$ _____
B. Attorney's Fee Paid by Employer	_____	\$ _____
C. Attorney's Fee Paid by Claimant (Non-contingent fees only)	_____	\$ _____

File this form with the Claims Department according to R.67-414 and R.67-1204. A person, other than the claimant, receiving benefits should sign on the line provided. * Do not include as medical costs fees paid for expert testimony, fees for determining carrier's liability, costs of autopsy, birth and death certificates and impartial examination. Form 19 must be filed within 16 days of final payment of compensation. Form 19 must be filed when a claim is denied.